State of Vermont
Adult Services Division
TBI Program

DOCUMENTATION TO BE KEPT ON FILE WITH PROVIDER AGENCY

1. Life Skills Aide Report
    - Tracks activities and progress
    - Providers may choose to use either the LSA Daily Report or the LSA Weekly Report

2. Case Management Reporting Log
    - Substantiates hours billed
    - Serves as record of activities

3. Care Conference Minutes with appropriate signatures
    - Documents results of monthly team meetings

4. A weekly activities schedule
    - Promotes independence
    - Provides consistency and structure

5. Admission / Transfer / Discharge Checklist
    - Required to be completed when transitioning a consumer to another program.

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PROCEDURES FOR COMPLETING DAILY LIFE SKILLS AIDE REPORT

When this form is used over a significant period of time it will substantiate the consumer's progress or lack of progress and the development of future program planning by case managers.

When consumers have behavioral issues it is important to describe what was happening at the time of the inappropriate behavior in detail. This is useful in developing strategies on how to assist the recipient in developing coping skills in stressful situations.

A copy of these reports must be kept on file in the consumer's record for review by the State upon request.

Life Skills Aide:
Name of the Life Skills Aide working with the consumer.

Provider Agency Name:
List the Name of the agency providing services.

Consumer's Name:
List the consumer's name

Date of Service:
Indicate the day you work with the consumer in the community.

Independent Living / Community Re-entry Skills Guidelines:
Rate all areas for each day and the total hours spent with the recipient. Once an area is identified for the day's activity, then the comments/narrative section needs to specifically describe what the activity was and the results/progress.

Narrative:
Use this section to describe the specific tasks or activities and the results for that day.

Comments:
This section is designed to report any significant progress, challenges, and observations related to that activity.

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DAILY LIFE SKILLS AIDE REPORT

Life Skills Aide: _____

Provider Agency: _____

Consumer's Name:_____

Date of Service: _____

Independent living / community re-entry skills focused on (enter the results/progress number code for each applicable area):

1 – 2	Unable to Perform	3 – 4	Severe Difficulty
5 – 6	Needs Assistance or Cueing	7 – 8	Independent
9	Not applicable		

_____ Physical Development & Mobility
_____ Communication / Cognitive Skills
_____ Eating Behaviors
_____ Food Preparation / Cooking
_____ Personal Hygiene / Grooming
_____ Health / Safety
_____ Other, please describe: _____

_____ Social Behavior / Leisure Time
_____ ADL's and Household Chores
_____ Budgeting & Numerical Skills
_____ Transportation & Travel
_____ Vocational Skills

Narrative - description of activity:

Comments: (use back of form or additional paper for additional comments or suggestions)

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PROCEDURES FOR COMPLETING DAILY LIFE SKILLS AIDE REPORT

Purpose:
When this form is used over a significant period of time it will substantiate the consumer's level of progress and lend guidance to development of future program planning by the case manager and the individual receiving services. Additionally, this form can be used as a quick reference tool to determine: program goals to work on, consumer progress, commentary for effective rehabilitation strategies or problematic behaviors that occur, and to maintain continuity of daily rehabilitation programming.

It is important for Life Skills Aides to accurately describe their observations each day. This information will be key in developing the consumer's TBI Evaluation.

When consumers exhibit behavioral challenges, it is important to describe the ABCs:
A - Antecedent, what was happening prior to the behavior?
B - Behavior, describe the behavior itself. What actually occurred?
C - Consequence, what needed to be put in place to stop the undesired behavior?
Describing the ABC's will help the case manager and rehabilitation team develop a consistent, structured program aimed at helping the consumer recover from his/her brain injury.

A copy of these reports must be kept on file in the consumer's record for review by the State upon request.

Recipients Name:
Write in the individual's name.

Life Skills Aide:
The Life Skills Aide writes in his/her initials in the appropriate day.

Provider Agency:
Write in the name of the agency providing services.

Week Services Provided:
List the range of dates covered on the report.

Goals/Activities to Track:
List a general description of the goals to be worked on for each of the areas of rehabilitation.

Tracking Progress:
For each day, score the individual's progress using the results/progress scale listed at

the bottom of the page. Be sure the score corresponds with the goals listed under the Goals/Activities to Track column.

Narrative Comments:
On the back side of the report write additional comments/observations under the appropriate day. Be sure to include enough information so another Life Skills Aide or Case Manager will understand the behavior or incident observed, successful strategies used or client's comments (if recorded).

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LIFE SKILLS AIDE REPORT

Recipient's Name: _____

Life Skills Aide: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:

Provider Agency: **Week Services Provided:** to

GOALS/ ACTIVITIES TO TRACK:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Sat/ Sunday**
Physical Development/Mobility:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Communication & Cognition:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Eating Behavior:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Meal prep/Cooking:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Personal Hygiene:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Social Behavior/Leisure skills:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.

Health and Safety:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Laundry/ Clothing Care/ Home Duties:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Independent Travel:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Vocational Skills:	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Other:						

Results/progress: 1-2 – Unable to perform 3-4 -- Severe Difficulty 5-6 – Needs Assistance or Cuing
7-8-- Independent

Please make comments and document significant incidents from the week: (use back of form or additional paper for additional comments or suggestions if needed):

Monday—

Tuesday--

Wednesday--

Thursday--

Friday--

Saturday--

Sunday--

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PROCEDURES FOR COMPLETING CASE MANAGEMENT REPORTING LOG

Procedures:
This form is utilized in recording any activities involving case management services for which the program will be billed and provides an ongoing record of the amount of time and type of case management services required for each consumer.

It is expected that intensive services for new consumers may be required and a reduction of these intensive services for most consumers will happen as progress occurs. This monthly form should be kept with the case manager, and be available at the time a contact and service occurs for accurate reporting.

Case Manager:
The person responsible for the consumer's program in the reporting month. If someone else is filling in for the regular case manager, simply include their name and the date they started.

Date:
The day of the month the activities or telephone contact occurred.

Time:
Report time spent for each service (i.e., from 9:00 a.m. to 9:30 a.m.)

Type of Contact:
Type of contact to be reported may include, but is not limited to the following:

- Supervision of staff
- Developing daily activities schedule
- Budget management activities for each consumer
- Lengthy telephone calls involving the consumer's individualized programs or scheduling of appointments
- Monthly care conferences meeting
- Emergency situations/problem solving activities

Contact Results:
A summary of action resulting from the contact that was made.

Initials:
This is the initials of the case manager or individual who provided the service.

At the end of each month, this form must be filed in the consumer's record and made available for review upon request.

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CASE MANAGEMENT REPORTING LOG (SAMPLE)

Instructions: One form for each consumer is to be utilized monthly for documentation of the time spent in performing case management activities. The documentation in most instances can be brief or when necessary a separate sheet can be attached for a detailed report.

Consumer: _____ **SSN:** _____

Case Manager: _____ **Provider Agency:** _____

Date	Time Spent	Type of Contact	Contact Results	Initials

TOTAL TIME PER FORM: _____

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PROCEDURES FOR COMPLETING CARE CONFERENCE MINUTES

Purpose:
This form is utilized in recording Care Conference Team meetings and is meant only as an example of a document to be utilized by the Case Manager. The team will be comprised of the consumer, guardian, case manager, appropriate consultants, and caregivers. This may also include LSAs, educational personnel, TBI Program Manager, a Vocational Rehabilitation Counselor, primary care physician, physiatrist, therapist, and other professionals with expertise in traumatic brain injury. This team shall meet once a month or more often if deemed necessary. This is an opportunity for the members to discuss, review, and evaluate the plan of care, and establish goals for the next month.

It is the responsibility of the case manager to:

- Develop and schedule the team meetings
- Set the agenda, in consultation with the client and team members
- Establish roles, expectations, and functions of the team members
- Facilitate the discussion to include review and evaluation of the Care Plan and establish goals for the next month
- Distribute minutes of the meeting as requested by the members
- Direct, develop, implement, coordinate, supervise, and monitor the plan and goals as discussed by the team

Procedure:
Team meetings will be held and documented once a month or more frequently as deemed necessary. This document should include topics discussed, changes in the Care Plan, and goals for the following month. This record shall include the consumer's signature, which may result in changes in the TBI Service Plan. A copy of the team meeting minutes must be maintained by the Provider Agency and available on request by members of the team.

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CARE CONFERENCE MINUTES (SAMPLE)

Consumer: _____ **SSN:** _____

Location: _____

Present: _____

_____

_____

1. Case Management

2. Rehabilitation

3. Community Support

4. Respite

5. Environmental and Assistive Technology

6. Next Meeting

Signature: _____ Date: _____
Case Manager

Signature: _____ Date: _____
Consumer/Guardian

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PROCEDURES FOR COMPLETING A WEEKLY ACTIVITIES SCHEDULE

PURPOSE:
A schedule is necessary as an aid in assisting the individual in organizing their day. It promotes independence and is especially useful for those who experience short-term memory loss. This form is an example of a tool that can be used. Other examples that may be helpful include, but are not limited to: calendars, white boards, PDA's (Personal Data Assistant), etc. On a weekly basis, the consumer, with assistance from the Life Skills Aide (LSA), will develop an activity schedule. It should include appointments, leisure time, skill development activities, employment, etc. It should cover 24 hours/day, 7 days/week.

1. The schedule should be simple, basic and easily understood by the consumer and include his/her participation in the development. A copy must be available for the consumer.

2. Respite services as needed per the program limits are to be included in the weekly schedule. Respite services, when provided by family members, should also be identified on the recipient's weekly schedule.

*See attached copy of an example of a completed schedule.

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ACTIVITIES SCHEDULE CLIENT / LIFE SKILLS AIDE (SAMPLE)

CONSUMER NAME: _____ I.D. # _____

CAREGIVER: _____ TELEPHONE: _____ AGENCY: _____

WEEK: FROM _____ TO _____ LSA = Life skills Aide

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
LSA: a.m.	LSA: a.m.	LSA: a.m.	LSA: a.m.	LSA: a.m.	LSA: a.m.	LSA: a.m.
LSA: p.m.	LSA: p.m.	LSA: p.m.	LSA: p.m.	LSA: p.m.	LSA: p.m.	LSA: p.m.
TOTAL HOURS:	**TOTAL HOURS:**	**TOTAL HOURS:**	**TOTAL HOURS:**	**TOTAL HOURS:**	**TOTAL HOURS:**	**TOTAL HOURS:**

LSA TOTAL HOURS FOR WEEK: _____

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ACTIVITIES SCHEDULE CLIENT / LIFE SKILLS AIDE

CONSUMER NAME: Mary Sunshine I.D. # 012-34-5678

CAREGIVER: Min E. Mouse TELEPHONE: (802) 911-0911 AGENCY: Happiness 4 U

WEEK: FROM: 05/06/07 TO: 05/12/07 LSA = Life skills Aide

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
LSA: a.m.	LSA: Lisa a.m. 8 - 12	LSA: Jim a.m. 8 – 1	LSA: Lisa a.m. 10 – 12	LSA: Jim a.m. 9 – 12	LSA: Lisa a.m. 8 – 12	LSA: a.m.
Respite	7 – 8: ADL's 8: Breakfast with LSA 9:30: Pick up kitchen and room 10: work on weekly menu, grocery list 11:30 prepare lunch and pick up	9:30: Collect & sort laundry 10: grocery shop for week 12: bag lunch at Laundromat	10: speech therapy 12: lunch out	10: library 12: lunch out	10: speech therapy 12: bag lunch	Respite with sister
LSA: p.m.	LSA: Lisa p.m. 12 - 4	LSA: Joe p.m. 1 - 4	LSA: Lisa p.m. 12 – 4	LSA: Jim p.m. 12 - 4	LSA: Lisa p.m. 1 – 4	LSA: p.m.
6: Respite ends 6-9: Leisure time 9: bedtime & meds	1 – 4: attend gym 4: leisure time 5: supper guest, Goofy 7: Leisure time 8: snack	1: cognitive activity (card games, crafts) 4: leisure 5 – 7: supper, news, 8: snack	1: - 3: attend gym 3 – 5: math, reading, writing	1: - 4: volunteer at food bank 4 – 5: leisure, 5 – 11: Go to local car races at track	1: - 3: attend gym 3 – 5: math, reading 5 – 9: rent movie, watch movie and popcorn	
TOTAL HOURS:	**TOTAL HOURS: 8**	**TOTAL HOURS: 8**	**TOTAL HOURS: 6**	**TOTAL HOURS: 7**	**TOTAL HOURS: 8**	**TOTAL HOURS: 0**

LSA TOTAL HOURS FOR WEEK: 37

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ADMISSION / TRANSFER / DISCHARGE CHECKLIST

Application Procedures Checklist:

- ☐ After going through application process, Individual gets approved for TBI Program and has Community or Long Term Medicaid
- ☐ Individual/Guardian is contacted by mail with list of potential Provider Agencies
- ☐ TBI Program Manager is notified with the agency of choice
- ☐ TBI Program staff will contact the provider of choice and will give the Provider Agency the option to agree to provide services or chose to pass
- ☐ If agency of choice chooses to pass, another agency can be selected
- ☐ If chosen agency agrees to provide services, the guardian / consumer / caregiver will be contacted and coordination and transition to the TBI Program will begin
- ☐ Team meeting occurs with TBI Program, referring provider, family, consumer, etc
- ☐ All pertinent releases are signed by guardian and medical records are sent
- ☐ Discharge plan developed to transfer consumer to TBI Program

The Transferring Provider Should Provide the Following:

- ☐ Info on pre-injury status (social history including substance abuse issues if pertinent, preferences, hobbies, interests) See back of form for more specifics
- ☐ Overview of current status and short and long term plans
- ☐ Any knowledge regarding history of outstanding offenses (if pertinent)
- ☐ Therapy (SLP, PT, OT, etc.) information, including current schedule, status, future recommendations, and referrals, if needed
- ☐ Medical appointments – dentist, eye doctor, etc., dates and locations of appointments, etc.
- ☐ Counseling referrals and recommendation information
- ☐ Name of doctors, phone numbers, and location of appointments
- ☐ Guardian contact information, phone number, best times to reach, etc.
- ☐ Medications with dosages and follow up for where to get prescriptions filled
- ☐ Vocational Rehabilitation referrals / transfers of cases to different location with counselor's name(s)
- ☐ Information on who will transfer belongings and transportation on day of transfer
- ☐ Review roles & clarify with family, provider, etc, (continue to follow up with family)
- ☐ Develop checklist for family (make sure that family is delegated specific responsibilities to keep them involved and to help empower!)
- ☐ Review schedule of weekly activities
- ☐ Medical documentation, past TBI ILAs, TBI Service Plans, etc. (if not transferring from another TBI provider, TBI Program staff will mail documentation)
- ☐ Schedule next team meeting
- ☐ A Discharge Summary (final TBI Evaluation with recommendations) will need to be sent to TBI Program staff and transferring provider when an individual is transferred to another provider or discharged from the program.

Listed below is some information on common Post TBI Health Issues to be aware of and for providers to gather/share information on. Please gather (if accepting someone into services) or provide (if transferring) information on all pertinent areas listed below for the future service provider.

Physical conditions the injury or accident such as:

- ☐ Impaired mobility- esp. balance issues
- ☐ Pain
- ☐ Seizures
- ☐ Shunts
- ☐ Sleep disturbances
- ☐ Spasticity
- ☐ Urinary incontinence
- ☐ Sensory deficits
- ☐ Impaired thermoregulation
- ☐ Skin and hair changes
- ☐ Arthritis
- ☐ Weight changes
- ☐ Thyroid conditions (in women)
- ☐ Sexual dysfunction
- ☐ Heterotopic ossification
- ☐ Bone and nerve injuries

Emotional and Mental Health issues:

- ☐ Grief
- ☐ Depression
- ☐ Substance abuse issues
- ☐ Behavior issues

Cognitive issues:

- ☐ Impaired short or long term memory
- ☐ Impaired attention and concentration
- ☐ Impaired executive functioning
- ☐ Impulsivity
- ☐ Disorientation
- ☐ Speech disturbances/ language deficits

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MANDATED REPORTER PROTOCOL

Please refer to mandated reporter protocol located in Section X.

Substantiated occurrences are to be reported to TBI Program Manager or designee.